

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **10418**
Registrar's No. **2252**BIRTH NO. **74675-53** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

FILED MAR 25 1954

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN Ferguson 4119	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hospital		e. STREET ADDRESS (If rural, give location) 259 Reasor Drive -	
3. NAME OF DECEASED (Type or Print) a. (First) Karen b. (Middle) Rose c. (Last) Schultz		4. DATE OF DEATH (Month) (Day) (Year) 3 - 10 - 54	
5. SEX Female		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married		8. DATE OF BIRTH Sept. 4, 53	
9. AGE (In years last birthday) 6		10. IF UNDER 1 YEAR Days 6	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Walter G. Schultz		13b. MOTHER'S MAIDEN NAME Elaine Klenm	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME E. Johnston		ADDRESS 500 S. Kingshighway	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchitis INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Mongolism DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 3254	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2 - 27, 1954 to 3 - 10, 1954 , that I last saw the deceased alive on 3 - 10 - 1954 , and that death occurred at 12 Noon m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Wm. G. Kluebers MD		23b. ADDRESS 500 S. Kingshighway	
23c. DATE SIGNED 3-10-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-12-54	
24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. MAR 11 1954		REGISTRAR'S SIGNATURE J. Earl Smith MD	
FUNERAL DIRECTOR'S SIGNATURE White Chapel		ADDRESS Ferguson Mo.	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Eleana Province*

Licensed Embalmer No. *340*

P. O. Address *Jennings*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.